



Name: _____

Address: _____

Date of birth: _____

Occupation: _____

Have you attached
your original
group certificate
with the form?

Do you have private
health care insurance: _____

FORM A

If yes:

Fund: _____

Member Number: _____

Days with fund: _____

Other information: _____

Signature: _____ Date: _____

PLEASE SEND "FORM A" AND YOUR ORIGINAL GROUP CERTIFICATE TO THE FOLLOWING ADDRESS:

**allRETURNS TAX AGENTS
PO BOX 5206
MARRICKVILLE NSW 1475**

WE WILL BE IN CONTACT WITH YOU SOON!